Alan V. Pavilanis, MD, CCFP

Ethical Questions in Adolescent Contraception

SUMMARY

Ethical problems often revolve around the conflicts of the models of beneficence and autonomy. Adolescents present a particular complication in their own struggle for autonomy. The physician is confronted with the further dilemma of sorting out the role of parents and the role of the adolescent patient in decision making. Furthermore, as adolescents develop their own moral code, they may lack consistency in their actions and opinions. The physician must examine the total context in arriving at a decision. The prescription of contraception is taken as an example of a common ethical dilemma. (*Can Fam Physician* 1989; 35:1317–1320.)

RÉSUMÉ

Les questions d'ordre éthique tournent souvent autour des conflits suscités par les modèles de bienfaisance et d'autonomie. Les adolescents, en quête de leur autonomie, sont source de complication bien particulière. Le médecin se retrouve souvent confronté au dilemme de départager le rôle des parents et le rôle de l'adolescent pour en arriver à une décision. Pour compliquer le tableau, à mesure que les adolescents développent leur propre sens moral, on peut constater un manque de constance dans leurs opinions et leurs gestes. Le médecin doit examiner le contexte global pour en arriver à une décision. Afin d'illustrer ce que représente un dilemme éthique, l'auteur utilise l'exemple de la prescription d'un contraceptif.

Key words: adolescents, contraception, abortion, decision making

Dr. Pavilanis is Director of Adolescent & Youth Medicine Service, The Montreal Children's Hospital, and Assistant Professor of Family Medicine and of Paediatrics at McGill University. Requests for reprints to: Adolescent and Youth Medicine Service, The Montreal Children's Hospital, 2300 Tupper Street, Montreal, P.Q. H3H 1P3

> To the trained eye, every patient presents an ethical problem.
>
> *N. Fost*[1]

PHYSICIANS MAKE decisions on a moment-to-moment basis. That these decisions are "ethical" in nature may easily be forgotten. The discussion of the ethics of a case often centres around a specific controversy. The lack of a seemingly unresolvable ethical conflict does not imply that ethics had no place in the decision making. Whether the physician considers the advisability of discussing the risks of aspirin, or whether he wonders if a parent should be told that a medical student or resident is performing his first procedure on a child, the physician should realize that there is no escape from moral problems.[2]

The practice of adolescent medicine provides fertile ground for such "commonplace" ethical dilemmas. Adolescent medicine is defined by a specific target population that requires a specific approach in order to provide effective medical care. It is not so much the technical complexity of the specific pathologies seen as the complexity of the doctor-patient relationship that makes this field challenging. How a physician approaches teenage patients is as much a question of personality as of training as of medical ethics.

To illustrate the ethical dilemmas common in the practice of adolescent medicine, I have chosen to focus on contraception, including a brief discussion of abortion as it pertains specifically to teenagers. Recurring themes in the treatment of adolescents are the ethical questions that re-

volve around the doctor-patient relationship.

Adolescence

Adolescence is generally regarded as that period of life that lies between childhood and adulthood. It starts at the onset of puberty and ends with the assumption of a fully independent adult role in society. The teenager moves gradually, and fitfully, from using concrete thought, living in the here and now, to using formal operational thought, when he or she is capable of examining long-term consequences and options.[3]

The adolescent must accomplish a series of so-called psychosocial tasks. These include separation from the family, the development of a sexual identity, the establishment of life and career goals, and the development of a personal moral and ethical code. It is not surprising that adolescents are inconsistent, take risks, and often express opinions or act in ways that are contrary to previous experience with the same individual.[2,4]

An understanding of this development and the ability to assess the level of maturity of each patient independent of chronological age, are central to the delivery of effective care to adolescents. These qualities are also central to the examination of the ethics of that care.[4]

An Ethical Approach

In this paper, I shall not attempt to review the principles of medical ethics. Suffice it to say that the universal applicability in practice of a "moral rule", however sound, is generally not deemed possible. Conversely, persons with widely differing moral principles often have no difficulty in agreeing on a course of action.[2]

It is common to refer to two models of ethical decision making: the beneficence model and the autonomy model.[2] While the concept of beneficence, or "doing good", is central to the practice of medicine or, for that matter, child-rearing, the issue of "Who benefits most?" arises to cloud this seemingly simple principle. Furthermore, it leaves unresolved the conflict of who decides in cases of disagreement. It might be assumed that "the expert" should decide. Or the duty might be assigned to "the most responsible person".

An alternative approach is to use the autonomy model, where the values and the beliefs of the patient are of primary import in the decision making process. This right to self-determination has important legal as well as philosophical origins.

The conflict that can be generated between these two models is inherent to the practice of medicine. The resolution of this conflict may not be obvious, and neither model can be rejected out of hand when considering a dilemma.[2]

The Trouble with Adolescents

Adolescents provide a living laboratory to complicate further the clash between beneficence and autonomy. In practising medicine with small children, it would be accepted that the "autonomy" of the child would be vested in the parent, who assumes a paternalistic protective role. Teenagers, however, have reached a stage of development where their struggle for independence from their parents is strategically important to their maturational process.

Thus, in dealing with adolescents, there is a risk of blurring the role of the three major participants. Are parents in a position to decide how their teenage children should be treated? Is the teenager mature enough to decide for himself? Apart from the difficulty of deciding with whom to deal primarily, a physician can find himself, beyond the role of benefactor, slipping into a role of parent! How does one gain the trust of an adolescent so as not to be viewed as another external authority figure?

The issues of growing up provide a living example of the tangled relationship between beneficence and autonomy. And the triangular relationship among teenager, parent, and doctor can be very complex. Indeed, the approach to the adolescent patient must be predicated on the physician's evaluation of the teenager's psychosocial maturity and not on the patient's age or some other rigid criterion. Most important, physicians must be aware that as teenagers move from dependence to independence (and back again!), inconsistency and shifting values are normal phenomena.[4]

Thus there emerges the legal provision for minors to have access to emergency care and to have access to care around some specific pathologies, such as sexually transmitted diseases, without parental consent. The emancipated minor is one who chronologically might be considered immature, but who lives independently. And increasingly, the concept of the mature minor is becoming accepted. The mature minor is still dependent on his parents, but appears able to make reasoned judgments. There is a growing body of opinion and tradition that the physician may treat these patients without discussion with the patient's parents.[5,6] It is generally considered desirable, if not absolutely necessary, that parents be aware of what care their teenaged children are receiving.

Contraception: A Practical Example

The definition of one's sexual being, sexual experimentation and, ultimately, sexual intercourse is an integral part of adolescent/young adult maturation. As societal norms change, sexual activity has occurred at an earlier and earlier age. Even if one's moral code derives from a tradition of sexual abstinence in adolescence, the ethical physician cannot, and must not, ignore the reality of adolescent sexuality.

In fact, adolescents are all too often subjected to a double standard: "Do as I say, not as I do." In a world where divorce, infidelity, and abortion are common, one cannot impose an outdated model, however idealistic, on teenagers. Given changing mores, a truly valid model of ethical behaviour would be difficult to define. Thus, ethics and contraception must be viewed in a cultural global context, as well as in a personal context.[7]

Furthermore, it is clearly of interest to society as a whole that adolescent pregnancy has great health, social, and political implications in that it is associated with prematurity, low birth weight, infant mortality, learning problems, delinquency, poverty, and dependency.[6] And the number of pregnancies in young adolescents is increasing.[6,8,9]

It has been proposed that medical intervention in the field of contraception should be based on the concepts of freedom, equality, and general welfare.[6] This entails access to information, to education, and to service. It also entails the right to make personal decisions.

It can further be argued that the prevention of adolescent pregnancy benefits not only the teenager but society as a whole. The question of competing rights (e.g., parent vs. child), however, is not addressed in this approach. Practising physicians are often caught in the middle of the debate between those who argue that favouring adolescent autonomy will decrease morbidity and mortality, and those who insist that favouring parental control and responsibility will protect children from their own irrational acts.[6]

It has been proposed that physicians should be educators — and be wary of the trap of blatant paternalism![7] Whenever possible, they should attempt to persuade adolescents to involve their parents in decisions concerning contraception and abortion.

Treatments should be individualized and based on each teenager's needs, not on preconceived rules.[10] And physicians should be well aware of the laws that govern such professional activities in their specific communities.[5,6]

In summary, then, the physician must navigate the delicate waters between treating the adolescent as a child who is the responsibility of his/her parents and treating him or her as an independent adult. Usually the adolescent is neither.

Ethics and Confidentiality

The right to confidentiality is generally viewed as one of the fundamental rights of the patient.[9] The problem is to determine when, on the sliding scale of adolescent maturity, the child's decisions override the parents'. The obligation to respect the teenager's privacy and confidentiality increases as his maturity increases.

It is, of course, not even as simple as that. Other external factors influence a physician's decision in this regard. The respect of confidentiality is one of the cornerstones of the practice of adolescent medicine, and with good reason. An adolescent patient who has reason to believe that what he tells a doctor will automatically be relayed to parents or other authority figures is unlikely to be open and honest with his physician.[11] The more mature and competent a minor, the greater his right to privacy and autonomy. In fact, irresponsible parents lose some of their authority as well.

There is no formula for working out a simple answer in these cases, and the physician must use his or her judgment constantly. It is highly conceivable that a pregnant mature minor may be misinformed about her parents' thoughts on abortion, and that the physician may judge it in her best interests to involve the parents against her will. It is to be hoped that this strategy would resolve the misunderstanding and result in a happier outcome for all concerned.[12]

A Global Approach

It is necessary to evaluate the entire situation when dealing even with issues which seem as simple as adolescent contraception. Dealing with psychic conflicts in teenagers requires a careful evaluation of the child, the parents, the specific situation, and of the physician her/himself.[12]

The physician particularly must evaluate personal loyalties in the context of doing the greatest good. Divided loyalties will be a continuing ethical dilemma for every doctor who cares for teenagers. Thus it may well be that it is precisely those adolescents who are most eager not to have their parents informed who are the ones most in need of their parents' involvement in treatment. This therapeutic consideration is quite distinct from an administrative one, which would have parents informed as a matter of policy.[13,14]

The Contraceptive Prescription

The physician practising adolescent medicine must address a series of ethical evaluations. With regard to contraception, I shall concentrate on the teenage girl. But it should surely be mentioned in passing that our traditional neglect, as a profession, of working to encourage teenage boys to accept responsibility for contraception raises a host of ethical questions. Simply because, in our society, it is often the girl who suffers the more severe consequences of an unwanted pregnancy, is it right to concentrate most of our educational efforts on girls? We know that up to 70% of girls experiencing their first sexual intercourse either used no contraception at all, or used an ineffective method. Would we not have a better chance of lowering this figure if we involved both members of the couple in responsible contraceptive counseling?[15]

Then the physician must consider the medical risks of contraceptive methodology against the medical risks of pregnancy. The difference between a 13-year-old girl and an 18-year-old girl can be quite great. First and foremost, the thirteen-year-old may still be physically immature.

But what of her social maturity? Although a correlation exists between physical and social maturity, social maturation must be evaluated separately. Of first importance is a social evaluation of her status relating to her personal maturity: How far has she progressed with the psychosocial tasks of adolescence?

And then what of her relationship with her peer group and her sexual partner? The ethical, medical practitioner will evaluate the nature of the sexual relationship. Is it frankly abusive? Is there incest or an unwanted relationship with an older adult? Even if the teen is happy in the relationship, the doctor must consider the possibility that a sexual relationship between an older adult and a younger teen is an abusive one.

Even in circumstances where there is no age gap, the girl may be assuming an unpleasant, submissive role in order not to lose her boyfriend. The physician has an ethical role here that goes beyond a simple prescription to prevent pregnancy. His or her counselling and intervention must take into account the entire context of the adolescent's sexual activity.[16,17]

What, then, of the teenager's relationship with her parents? Is her sexual activity a form of rebellion: so-called "sexual acting out"?[17] Are the parents' rules incompatible with the values of the adolescent and her peer group? How willing to negotiate is the family as a whole?

What about the parents themselves? What are their rights and obligations? Often parents propose double standards. Often the conflicts over a child's sexual activity lie rooted in the parents' own unresolved problems. They may harbour conflicts from their own adolescence, or have ambivalent feelings stemming from the adolescent's early childhood. Struggles over a child's sexual activity may stem principally from deeper

problems within the family structure. In fact, sexual rivalry or sexual attraction between parent and child can underlie conflicts relating to sexual activity and contraception.[17]

Who has the right to decide? Can doctors, parents, or teenagers themselves make decisions that are divorced from the attitudes of the society in which they live? Current controversies, particularly in the United States, highlight the role that a government can play in attempting to determine who shall, and who shall not have access to contraception and abortion.

I have stated earlier that adolescent pregnancy has consequences for society as a whole. And yet society can often impose a sort of double standard on adolescents. The role models for today's adolescents are too often those of "self-actualisation" rather than moral responsibility. Low self-esteem and a moral void can lead to sexual behaviour coupled with a lack of responsibility (or lack of contraception) that can appear difficult to understand unless the society which produced this behaviour is examined.

Physicians have a role, then, in promoting effective education. This education must go beyond the simple explanation of biology to teenagers. It must examine values. Education is more than information. And doctors, as respected members of society, must take on some role as educators. At least they must play a role in their communities to foster effective contraceptive education. They must promote an open discussion: a normalization of what is already the norm.[7,16,17]

And lastly, once pregnancy has occurred, whose interests should take precedence in the decision as to whether or not the pregnancy should continue: those of the fetus? those of the adolescent? those of the adolescent's parents? those of society? Should a 15-year-old girl with a disturbed family background and no means to support a child, but for whom the future child represents a focus of love and validization be encouraged to have an abortion? Or should the emotionally and financially stable 18-year-old for whom the future child is an impediment to family and career goals be encouraged to go ahead with an abortion? Perhaps the most important, and the most difficult, guide in answering these questions is that the physician should respect the adolescent with whom he is dealing.[7]

Conclusions

I have tried to illustrate that a special concern in approaching ethical problems with adolescents is understanding the nature of adolescence itself. The physician must understand adolescent development as well as parental and societal attitudes towards adolescence.

The physician must also respect the adolescent and avoid becoming a surrogate parent himself. He must evaluate the context of each individual case, and be careful to examine the ethical issues. He must avoid simple acceptance of a prescribed code, be it the teenager's, the teenager's parents', society's, or his own.

Ultimately, his ethical approach will be to balance models of beneficence and autonomy, and thus arrive at a solution that best suits the situation for each individual patient. ■

References

1. Fost N. Ethical Problems in Paediatrics. *Current Problems in Paediatrics* 1976; (6):3.

2. Beauchamp TL, McCullough LB. *Medical ethics: the moral responsibilities of physicians*. Englewood Cliffs, NJ: Prentice-Hall, Inc., 1984: 20, 22–51, 142–4.

3. Felice ME. Adolescence. In: Levine MD, Carey WB, Crocker AC, et al., eds. *Developmental - behavioral paediatrics*. Philadelphia: W. B. Saunders Co., 1983: 133–49.

4. Coulter DL, Murray TH, Cerreto MC. Practical ethics in paediatrics. *Current problems in paediatrics*. 1988; 18(3): 137–98.

5. Jonsen AR, Siegler M, Winslade WJ. *Clinical ethics*. New York: MacMillan Publishing, 1982: 90–1.

6. Silber TJ. Ethical and legal issues in adolescent pregnancy. *Clin perinatol* 1987; 14(2):265–70.

7. Doucet H. Ethique et contraception à l'adolescence. *Union medical du Canada* 1982; (Oct):923–6.

8. Guilbert E. Médecine de l'adolescence: la contraception. *Le Medecin du Québec* 1985; 6:27–32.

9. Doucet H. Bioethique et médecine d'adolescence. *Médecine et Hygiène* 1982; 40:861–4.

10. Gerber P, Rahemtula A. Who has the right to advise children on birth control? *Med J Australia* 1986; 144(8):419–23.

11. Cogswell BE. Cultivating the trust of adolescent patients. *Fam Med* 1985; 17(6):254–8.

12. Green J, Stewart A. Ethical issues in child and adolescent psychiatry. *J Med Ethics* 1987; 13(1):5–11.

13. Arnstein RL. Divided loyalties in adolescent psychiatry: late adolescence. *Social Science Med* 1986; 23(8):797–802.

14. Bruckner J, Physical therapists as double agents: ethical dilemmas of divided loyalties. *Physical therapy* 1987; 67(3):383–7.

15. Pavilanis AV. Adolescent contraception: an overview. *Can Fam Physician* 1988; 34:1095–8.

16. Pavilanis AV. Enhancing adolescent compliance with medical regimens. *Can Fam Physician* 1986; 32:2389–92.

17. Pavilanis AV. Helping families deal with adolescent sexuality. *Can Fam Physician* 1985; 31:1657–61.